

Primary Health Group - Capital City

Date: 07/22/2025

Fax to:

From:
Roderick Haithcock, MD

Fax: (804) 325-8801
Telephone: (804) 782-1193

PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FOR BACK ORTHOSIS**Please Send RX Form & Pertinent Chart Notes****Fax No:****PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS**

Date: 07/21/2025 First: Annie Last: Banks DOB: 8/14/1943 Gender Female Address: 2911 Old Gun Rd West City: Midlothian State: VA Postal Code: 23113 Patient Phone Number: 8047945835 Primary Ins: Policy #: 2RJ5U01GD88 Private Ins: ATENA Policy #: Height: 5.3 Weight: 125	Physician Name: Roderick Haithcock MD NPI: 1801884580 Address: 2230 W Broad St Ste 103 City: Richmond State: VA Postal code: 23220 Phone Number: 8043258801 Fax Number: 8047821193
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This patient is being treated under a comprehensive plan of care for back pain.

I, the undersigned, certify that the prescribed orthosis is medically necessary for the patient's overall well-being. This patient has suffered an injury or undergone surgery. In my opinion, the following back orthosis products are both reasonable and necessary in reference to treatment of the patient's condition and/or rehabilitation. My patient has been in my care regarding the diagnosis below. This is the treatment I see fit for this patient at this time. I certify that this information is true and correct.

DIAGNOSIS: Provider can simply cut off the diagnosis which they don't find appropriate

Lumbar/ Lumbosacral Intervertebral Disc Degeneration (M51.36)
 Other intervertebral disc degeneration, lumbosacral region (M51.37)
 Spinal Stenosis, lumbar region (M48.06) ~~X~~
 Spinal stenosis, lumbosacral region (M48.07)
 Other intervertebral disc disorders, lumbosacral region (M51.87)
 Low back pain (M54.5)
 Unspecified osteoarthritis, unspecified site (M19.90)
 Other/Explain (Include Code): _____

Our evaluation of the above patient has determined that providing the following back pain orthosis product will benefit this patient:

DISPENSE:

L0627 LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF

Estimated length of need (# of months): _____ 99 _____ 6 - 99 (99= LIFETIME)

Physician Signature: Roderick Haithcock Date: 07/22/25

Physician Name: Roderick Haithcock MD**NPI: 1801884580**

PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FOR DELUXE KNEE ORTHOSIS**Please Send RX Form & Patient Chart Notes****Fax No:714-515-4008****PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS**

Date: 07/21/2025 First: Annie Last: Banks DOB: 8/14/1943 Gender: Female Address: 2911 Old Gun Rd West City: Midlothian State: VA Postal Code: 23113 Patient Phone Number: 8047945835 Primary Ins: Policy #: 2RJ5U01GD88 Private Ins: ATENA Policy #: Height: 5.3 Weight: 125		Physician Name: Roderick Haithcock MD NPI: 1801884580 Address: 2230 W Broad St Ste 103 City: Richmond State: VA Postal code: 23220 Phone Number: 8043258801 Fax Number: 8047821193
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This patient is being treated under a comprehensive plan of care for knee pain.

I, the undersigned; certify that the prescribed orthosis is medically necessary for the patient's overall well-being. In my opinion, the following knee orthosis products are both reasonable and necessary in reference to treatment of the patient's condition and/or rehabilitation. My patient has been in my care regarding the diagnosis below. This is the treatment I see fit for this patient at this time. I certify that this information is true and correct.

DIAGNOSIS: Provider can simply cut off the diagnosis which they don't find appropriate

Rheumatoid Arthritis without rheumatoid factor, rightknee (M06.061)

Rheumatoid Arthritis without rheumatoid factor, left knee (M06.062)

Unilateral Primary Osteoarthritis, Rightknee (M17.11)

Unilateral Primary Osteoarthritis, left knee (M17.12)

Bilateral Primary Osteoarthritis (M17.0)

Chronic instability of knee, rightknee (M23.51) **X**

Chronic instability of knee, left knee (M23.52) **X**

Other /Explain: _____

AFFECTED AREA:

KNEE:

Left Knee



Right Knee

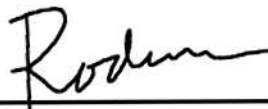


Our evaluation of the above patient has determined that providing the following knee orthosis product will benefit this patient

DISPENSE:



L1833 - Adjustable Flexion & Extension Joint (Unicentric or Polycentric), Medial-Lateral & Rotation Control, +/- Varus/Valgus Adjustment, Prefabricated, Off the Shelf; includes L2397 Suspension Sleeve

Length of need is 99 months unless otherwise specified : 99 6 - 99 (99= LIFETIME)

Physician Signature:**Date:**07/22/25**Physician Name: Roderick Haithcock MD****NPI: 1801884580**

Annie Banks

Roderick Haithcock, MD
Physician
Specialty: Internal Medicine

Progress Notes  
Signed

Encounter Date: 03/31/2025

Subjective

Patient ID: Annie Banks is an 81 y.o. female.

Chief Complaint

Follow-up for bilateral knee pain and low back pain

HPI

Back Pain:

Annie Banks is an 81-year-old female presenting with complaints of lower back pain. The pain is described as dull and aching, with moderate severity (rated 6/10). It has been gradually worsening over the past several months. The discomfort is persistent throughout the day, worsened by prolonged sitting, standing, or bending forward, and somewhat relieved with rest or use of a heating pad. She denies any radiation of pain to the legs, numbness, or tingling. She reports stiffness in the morning lasting about 30 minutes. No history of trauma or recent injury. She notes the pain has limited her mobility and daily activities, such as walking and housework.

Bilateral Knee Pain:

Patient also reports chronic pain in both knees, more pronounced on the right side. The knee pain is sharp and intermittent, rated 5–7/10 in intensity, and aggravated by walking, climbing stairs, and standing for extended periods. The discomfort has been present for over a year, progressively worsening. She experiences occasional swelling and stiffness, particularly in the morning or after prolonged rest. She has a history of chronic bilateral knee pain for the past 12 months, associated with a previous injury and aggravated by physical activity.

Review of Systems

Negative other wise mention in hpi

Objective

Physical Exam

HEENT: Negative

Chest: Clear

Heart: Rate rhythm

Abdomen: Soft and nontender

Musculoskeletal: The spine is normally aligned with no visible deformity. There is tenderness over the lower lumbar spine and paraspinal muscles, with reduced flexion and extension due to pain. Both knees show mild swelling and joint line tenderness, more pronounced on the right. Range of motion is limited by pain, but there are signs of deformity and instability.

Straight leg raise negative.

Back Examination:

Inspection reveals no visible deformities, swelling, or skin changes over the lumbar region. Palpation elicits tenderness over the lower lumbar spine and paraspinal muscles, without warmth or crepitus. Range of motion is mildly limited in flexion and extension due to discomfort, with pain noted at end ranges and during resisted extension.

Neurological exam shows intact lower extremity sensation and motor strength, with normal deep tendon reflexes. No signs of radiculopathy or sciatic tension on straight leg raise testing.

These findings are consistent with mechanical lower back pain, without neurological deficit

Bilateral Knee Examination:

Inspection reveals mild bilateral swelling, with no visible deformities, skin discoloration, or open wounds. Palpation reveals tenderness over the medial and lateral joint lines, more on the right, without warmth or crepitus. Range of motion is mildly limited in flexion due to discomfort, with pain at end ranges and during resisted extension and flexion.

Neurovascular assessment shows intact distal pulses and normal capillary refill, with preserved sensation in the lower extremities. Motor strength is intact, and ligament stability tests (anterior drawer, valgus/varus stress) are normal.

These findings are consistent with bilateral knee inflammation, more prominent on the right, with no evidence of neurovascular compromise.

Assessment/Plan

1. Spinal stenosis, lumbar region

Overview:

Dispense L0627 lumbar orthosis for management of lower back pain and instability.

Bracing is medically necessary due to spinal tenderness, reduced lumbar range of motion, and impaired mobility.

Patient is ambulatory and requires lumbar stabilization to improve posture, decrease pain, and support functional activities.

Patient demonstrates potential for functional improvement with consistent use of the orthosis.

2. Chronic pain syndrome

Overview:

UM:

3. Dorsalgia, unspecified

Overview:

UM:

4. Cardiomegaly

Overview:

UM:

5. Essential (primary) hypertensionOverview:

UM:

6. PalpitationsOverview:

UM:

7. Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorderOverview:

UM:

8. Primary osteoarthritis involving multiple jointsOverview:

UM:

9. Age-related osteoporosis without current pathological fractureOverview:

UM:

10. Chronic instability of knee, unspecified kneeOverview:

Dispense bilateral L1833 knee orthoses for management of knee joint instability and pain. Bracing is medically necessary due to joint tenderness, swelling, reduced range of motion, and impaired ambulation.

Patient is ambulatory and requires medial-lateral and anterior-posterior knee stabilization to improve function and reduce fall risk.

Patient demonstrates potential for functional improvement with regular use of the orthoses..

Laxity Test

Anterior Drawer Test: Positive for ACL laxity, and reports pain in both knees.

Posterior Drawer Test: Negative for PCL laxity, with mild discomfort noted.

Lachman Test: Negative for ACL laxity, patient reports pain during the maneuver.

Varus Stress Test: Negative at 0°/30° for LCL laxity, pain elicited on lateral side.

Valgus Stress Test: Negative at 0°/30° for MCL laxity, with medial knee pain reported.

Pain indicates potential soft tissue involvement,

Other orders

Atorvastatin Calcium; Take 1 tablet (10 mg total) by mouth 1 (one) time each day. Dispense: 30 tablet;

Refill: 11

amLODIPine Besylate; Take 1 tablet (10 mg total) by mouth 1 (one) time each day. Dispense: 90 tablet;

Refill: 1

buPROPion HCl ER (SR); Take 1 tablet (100 mg total) by mouth in the morning and 1 tablet (100 mg

Additional Documentation

Vitals: BP 117/74 (BP Location: Left arm, Patient Position: Sitting, BP Cuff Size: Adult)
 Pulse 79
 Temp 36.6 °C (97.8 °F) (Temporal)
 Resp 16
 Wt 56.69 kg (125 lb)
 SpO2 94%
 BMI 28.12 kg/m²
 BSA 1.88 m²

Flowsheets: Vitals Reassessment

Orders Placed

PULSE OXIMETRY

Medication Changes As of 03/31/2025

	Refills	Start Date	End Date
Added: buPROPion SR (Wellbutrin SR) 100 MG 12 hr tablet	11	9/12/2024	9/12/2025

Take 1 tablet (100 mg total) by mouth in the morning and 1 tablet (100 mg total) in the evening. Do not crush, chew, or split. - Oral

Visit Diagnoses

Spinal stenosis, lumbar region M48.06
 Chronic instability of knee, unspecified knee M23.50
 Dorsalgia, unspecified M54.9
 Cardiomegaly I51.7
 Essential (primary) hypertension I10
 Palpitations R00.2
 Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder M51.9
 Primary osteoarthritis involving multiple joints M15.9
 Age-related osteoporosis without current pathological fracture M81.0

Electronically signed by Patricia Davidson MD on 03/31/2025